# EXHIBIT 1: MODEL INDIVIDUAL ENROLLMENT REQUEST FORM TO ENROLL IN A MEDICARE ADVANTAGE PLAN (PART C) OR MEDICARE PRESCRIPTION DRUG PLAN (PART D)

## Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan or Medicare Prescription Drug Plan

**To join a plan, you must:**

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

## When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit Medicare.gov to learn more about when you can sign up for a plan.

## What do I need to complete this form?

- Your Medicare Number (the number on your red, white, and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

## Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

## What happens next?

Send your completed and signed form to:

**By Mail:**

**Solis Health Plans**
9250 NW 36 Street, Suite-400
Doral, Florida 33178

**By Fax:**

**1-305-675-0933**

Once they process your request to join, they'll contact you.

## How do I get help with this form?

Call Solis Health Plans at 1(844) 447-6547. TTY users can call 711.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**IMPORTANT**

**Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.**

# 2022 Enrollment Request Form

Please contact Solis Health Plans, Inc. (HMO) if you need information in another language or format.

**To Enroll in Solis Health Plans, Please Provide the Following Information:**

**Please check which plan you want to enroll in:**

## SOUTH FLORIDA

| MIAMI DADE | |
|---|---|
| ☐ **SPF 001 (HMO)** H0982-001 | $0 Premium per month |
| ☐ **SPF 002 (HMO D-SNP)** H0982-002 | $34.30 Premium per month |
| ☐ **SPF 011 (HMO C-SNP)** H0982-011 | $0 Premium per month |

| BROWARD | |
|---|---|
| ☐ **SPF 007 (HMO)** H0982-007 | $0 Premium per month |
| ☐ **SPF 012 (HMO D-SNP)** H0982-012 | $34.30 Premium per month |

| PALM BEACH | |
|---|---|
| ☐ **SPF 008 (HMO)** H0982-008 | $0 Premium per month |
| ☐ **SPF 013 (HMO D-SNP)** H0982-013 | $34.30 Premium per month |

## CENTRAL FLORIDA

| ORANGE | |
|---|---|
| ☐ **SPF 005 (HMO)** H0982-005 | $0 Premium per month |
| ☐ **SPF 006 (HMO D-SNP)** H0982-006 | $34.30 Premium per month |

| HILLSBOROUGH | |
|---|---|
| ☐ **SPF 009 (HMO)** H0982-009 | $0 Premium per month |
| ☐ **SPF 010 (HMO D-SNP)** H0982-010 | $34.30 Premium per month |

OMB No. 0938-1378
Expires:7/31/2023

## Section1–All fields on this page are required (unless marked optional)

FIRST name: LAST name: Optional: Middle Initial:

| Birth date: (MM/DD/YYYY) | Sex: ☐ Male ☐ Female | Phone number: (      ) |
|---|---|---|

Permanent Residence street address (Don’t enter a PO Box):

| City: | Optional: County: | State: | ZIP Code: |
|---|---|---|---|

Mailing address, if different from your permanent address (PO Box allowed):
Street address: City: State: ZIP Code:

**Your Medicare information:**

**Medicare Number (MBI):** ______________________

**Answer these important questions:**

Will you have other prescription drug coverage (like VA, TRICARE) in addition to Solis? ☐ Yes ☐ No

Name of other coverage: ______________ Member number for this coverage: ______________ Group number for this coverage ______________

***For Special Need Plans (SNP) only***

***Solis offers two SNPS: D-SNPs for dual eligible individuals and C-SNPs for chronic-condition individuals:***

*D-SNPs are SNPs that restrict enrollment to individuals who are entitled to both Medicare and medical assistance from a state plan under Medicaid.*

Do you have Medicaid or receive assistance from a state plan under Medicaid?

☐ Yes ☐ No ______________________
Medicaid #

*C-SNPs are SNPs that restrict enrollment to special needs individuals with specific severe or disabling chronic conditions.*

Do you have a Chronic and disabling mental health condition, like Bipolar disorder, Major depressive disorder, Paranoid disorder, Schizophrenia or Schizo-affective disorder?

☐ Yes ☐ No

## IMPORTANT: Read and sign below:

- I must keep Hospital (Part A) or Medical (Part B) to stay in Solis Health Plans.
- By joining this Medicare Advantage Plan or Medicare Prescription Drug Plan, I acknowledge that Solis Health Plans will share my information with Medicare, who may use it to track my enrollment, to make payments,and for other purposes allowed by Federal law that authorize the collection of this information (see PrivacyAct Statement below).
- Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under State law to complete this enrollment, and
    2) Documentation of this authority is available upon request by Medicare.

| **Signature:** | **Today's date:** |
|---|---|
| | |

| If you're the authorized representative, sign above and fill out these fields: | |
|---|---|
| Name: | Address: |
| Phone number: | Relationship to enrollee: |

## Section2–All fields on this page are optional

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

Select one if you want us to send you information in a language other than English.

☐ Spanish

☐ Other ____________________________

Select one if you want us to send you information in an accessible format.

☐ Braille ☐ Large print ☐ Audio CD

Please contact Solis Health Plans at (844) 447-6547, if you need information in an accessible format other than what's listed above. Our office hours are October 1st to March 31st: 8am to 8pm EST, 7 days a week April 1st to September 30th: 8am to 8pm EST, Monday-Friday. TTY users can call 711.

Do you work? ☐ Yes ☐ No Does your spouse work? ☐ Yes ☐ No

## List your Primary Care Physician (PCP), clinic, or health center:

PCP Name PCP ID

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Provider Directory ☐ Dental Benefits

☐ Formulary ☐ OTC Catalog

E-mail address:

## Paying your plan premiums

You can pay your monthly plan premium including any late enrollment penalty that you currently have or may owe by mail. **You can also choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.**]

☐ Get a bill ☐ Deduction from Social Security ☐ Deduction from RRB

**If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium.** The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Solis Health Plans Part D-IRMAA.

**PRIVACY ACT STATEMENT**

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

**Typically, you may enroll in a Medicare Advantage plan only during the annual enrollment period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.**

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me. I moved on (insert date) ______________________.
- ☐ I recently was released from incarceration. I was released on (insert date) ______________________.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) ______________________.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) ______________________.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) ______________________.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) ______________________.
- ☐ I have both Medicare and Medicaid (or my state helps pay for my Medicare premiums) or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I am moving into, live in, or recently moved out of a Long-Term Care Facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) ______________________.
- ☐ I recently left a PACE program on (insert date) ______________________.

- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) ______________________________.
- ☐ I am leaving employer or union coverage on (insert date) ___________________________.
- ☐ I belong to a pharmacy assistance program provided by my state.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) ____________________________________.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) __________________________________.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.

Please contact Solis Health Plans at 1 (844)447-6547, TTY 711. If you need information in an accesible format or language other than what is listed above.

Our operating hours are:
October 1st to March 31st: 8am to 8pm EST, 7 days a week
April 1st to September 30th: 8am to 8pm EST, Monday-Friday

Solis Health Plans is a HMO with a Medicare contract. Our SNPs also have contracts with the Florida Medicaid program. Enrollment in Solis Health Plans, Inc. (HMO) depends on contract renewal.

Atención: Si usted hable español, servicios de asistencia en español, de forma gratuita, están disponible para usted. Llame al 1 (844)447-6547 (TTY 711).